Patient Health Questionnaire (PHQ-A)

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Are you currently: ☐ *on medication for depression* ☐ *not on medication for depression* ☐ *not sure?* ☐ *in counseling*

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, — or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each column				

10. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

11. In the **past year**, have you felt depressed or sad most days, even if you feel okay sometimes? ☐ **YES** ☐ **NO**
12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ **YES** ☐ **NO**
13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt? ☐ **YES** ☐ **NO**

Pediatric Traumatic Stress Screening Tool — 11 years and older

Sometimes violent or very scary or upsetting things happen. This could be something that happened to you or something you saw. It can include being badly hurt, someone doing something harmful to you or someone else, or a serious accident or serious illness.

Has something like this happened recently? ☐ Yes ☐ No

If 'Yes,' what happened? _____

Has something like this happened in the past? ☐ Yes ☐ No

If 'Yes,' what happened? _____

If you checked 'yes' on either question above, please continue below:

How much of the time during the past month...		None	Little	Some	Much	Most
1	I have bad dreams about what happened or other bad dreams.	0	1	2	3	4
2	I have trouble going to sleep, waking up often, or getting back to sleep.	0	1	2	3	4
3	I have upsetting thoughts, pictures, or sounds of what happened come to mind when I don't want them to.	0	1	2	3	4
4	When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.	0	1	2	3	4
5	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
6	I have trouble concentrating or paying attention.	0	1	2	3	4
7	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
8	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
9	I have trouble feeling happiness or love.	0	1	2	3	4
10	I try not to think about or have feelings about what happened.	0	1	2	3	4
11	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
12	I feel alone even when I'm around other people.	0	1	2	3	4

Pediatric Traumatic Stress Screening Tool — 11 years and older

Clinicians, please indicate actions taken:

☐ **No Action Taken**

Referrals: (check all that apply)

- ☐ Child Protection (DCFS / CPS)
- ☐ Crisis Evaluation / Emergency Department
- ☐ Trauma Evidence-Based Treatment
- ☐ Mental Health Integration (MHI)

In-office Interventions: (check all that apply)

- ☐ Sleep Education
- ☐ Belly Breathing
- ☐ Guided Imagery
- ☐ Progressive Muscle Relaxation

Patient Health Questionnaire (PHQ-A)

For Office Use Only:

Symptom score *(total # of answers in shaded areas)*:_____

Severity score *(total all points from all questions)*:_____

Source: Pediatric Traumatic Stress Screening Tool — 11 years and older
(Based on the UCLA Brief Trauma Screen)

Source: Patient Health Questionnaire Modified for Teens (PHQ-9)
(Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

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